

# **An Analysis of Scores and Reviewer Comments from CSXVI Grant Applications**

*USAID/BHR/PVC Child Survival  
Grants Program*

*September 11, 2000*



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The Child Survival Technical Support (CSTS) Project is funded by the Office of Private and Voluntary Cooperation, Bureau of Humanitarian Response (BHR/PVC), of the United States Agency for International Development (USAID), and is managed by Macro International, Inc. For further information on the Child Survival Technical Support Project, please contact: ORC Macro, 11785 Beltsville Drive, Calverton, Maryland 20705; Attn: CSTS Project; (301) 572-0823; fax: (301) 572-0983, e-mail [csts@macroint.com](mailto:csts@macroint.com); Internet: [www.childsurvival.com](http://www.childsurvival.com)



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## *Overview and Highlights*

### **A. Overview**

The Child Survival Technical Support Team (CSTS) at ORC Macro, Inc.—a results-based contract which provides support to the Child Survival Grants Program at USAID/BHR/PVC, its PVO grantees, and the CORE Group—conducted an analysis of the CS XVI grant applications as part of its on-going efforts to build the capacity of PVOs working in Child Survival.

The purpose of the following analysis is to provide key observations for the next cycle of applicants as they prepare to write applications for the CS XVII grant cycle. This section provides a summary of some of the key findings that emerged in the analysis of the CS XVI grant applications, and key themes that surfaced from a content analysis of reviewer comments. An overview of the application review process is included in section II of this document, including a discussion of the review committee. Section III provides some key observations for potential applicants.

It is important to note that the Child Survival Grants Program RFA is slightly revised and adapted each year, and that some of the considerations outlined in this report may not be applicable to this year's RFA. It is hoped that this report provides insight into those areas that were strongest and weakest in CSXVI applications, for the purpose of strengthening all applications submitted for CSXVII funding. However, incorporating the considerations in this report into your application does not guarantee an award. Potential applicants are strongly encouraged to thoroughly read the RFA and prepare an application that is responsive to the specific language contained therein.

### **B. Highlights of Findings**

A quantitative analysis of 43 CSXVI applications was conducted, aggregating individual reviewer scores across funding category and across evaluation criteria category. Highlights from this analysis include:

- No applications received a score higher than 90
- No Entry Grant applications received a score better than 62, and no Entry Grants were funded this year

- Applications that received a score of 77 and higher were funded in the New and Follow-on funding categories
- The highest score received for any application was 88.43; the lowest score received for any application was 35.78
- The average overall score for the CSXVI applications was 65.41
- More applications were submitted for New grants (23) than any other category
- No applications for mentoring grants were received for CSXVI
- “Budget” and “Problem Analysis and Strategy Options” were the highest scoring evaluation criteria in all funding categories with the exception of third-cycle grants, where “PVO Applicant” and “Problem Analysis and Strategy Options” scored highest.
- “Capacity Building” and “Sustainability” were the lowest scoring evaluation criteria in each funding category, except in third-cycle grants where “Capacity Building” and “Performance Monitoring and Evaluation” scored lowest.

Key themes emerged from a qualitative analysis of reviewer comments, and are outlined below:

**Responsiveness to the RFA**—A number of applicants’ scores were lowered by their failure to address major sections of the RFA. Some applications did not seem to reflect an understanding of PVC’s strategic objectives; others proposed inappropriate uses of funds such as purchase of vehicles or fundraising; others demonstrated a lack of understanding of national policies or the local cultural context. Still others used extremely small type sizes for exhibits such as budget tables, which made it hard for reviewers to read the documents. Entry-grant applications were the least responsive to the RFA.

**Capacity Building of the U.S. PVO**—This was an area that was not consistently addressed by applicants. While some applicants discussed recent organizational capacity assessments that had been conducted at the HQ level—and outlined how this grant would build on the strengths and challenges identified through those assessments—others did not include any specific discussion of capacity building at this level. In light of PVC’s strategic objective of “increasing the capacity of its funded grantees to promote sustainable service delivery,” the failure to address capacity building at this level lowered the overall scores of a number of applicants.

**Inclusion of Partners, Beneficiaries, and other Stakeholders**—The majority of low-scoring applications showed little evidence that proposed local partners were involved in developing the application, outside of furnishing a letter of commitment to participate in the program. Similarly,

these applications did not clearly state how the beneficiary community(s) would be involved in the implementation and evaluation of the program—aside from being recipients of services—and showed little understanding of how the proposed project would fit into the larger context of other development projects in the region. Higher-scoring applications described processes by which partners had worked strategically with their PVO in identifying the design, objectives, and focus of the program, and provided thoughtful descriptions of how the proposed program would fit into other related programs that were already running in the region (e.g. water and sanitation, food aid, HIV/AIDS, etc.)

**Performance Monitoring and Evaluation**—Applications which scored highly in this area featured clear results-based objectives that related not only to improvements in technical areas (EPI, malaria control, IMCI, etc.), but also to management and organizational capacity of local partners and community/district health infrastructure. These applications demonstrated an understanding of the array of tools that are necessary to take baseline measures and monitor progress at these multiple levels, and did not rely only on traditional knowledge, practice, and coverage surveys. These applications usually described a mixture of quantitative and qualitative techniques for collection baseline information, ranging from Health Facility Assessments, to Participatory Rural Appraisal, to Appreciative Inquiry-based strategies, to Lot Quality Assurance Sampling Techniques.

Those applications which scored low in this category featured primarily process-oriented indicators, and demonstrated little understanding of monitoring and evaluation systems that could be functional in the context of a child survival program.

**Technical Interventions**—High-scoring applications in this area clearly linked the proposed technical interventions to the existing health conditions and development landscape of the proposed region. These applications included strong justifications for choosing to implement a specific intervention based on the resources available for the program and the opportunities for creating sustainable service delivery. Similarly, these applications often included clear rationales for not undertaking a specific intervention, even if the need for that intervention was very high in the proposed target region. Such rationales ranged from simple explanations such as “this intervention is already being covered by another project nearby” to complex cost-analyses that demonstrated that more might be accomplished by implementing other less expensive interventions.

Nineteen of the applications featured an IMCI component this year and one external technical reviewer looked at all of these applications. A summary of his observations are included in an annex to this report.

## II

### *The Application Review Process*

The CS GP received a total of 48 grant applications for Child Survival Cycle XVI and awarded fifteen grants. Forty-three applications were reviewed and scored. Three applications were not reviewed or scored because the PVOs did not have authority to work in their respective countries. Two applications were not scored—but did receive written comments—because the USAID Missions did not support the proposed projects. This section provides an overview of the different funding categories, describes the application scoring system, and describes the process used for analyzing application scores for this report.

#### **A. Funding Categories**

In the FY 2000 RFA, PVOs could apply for cooperative agreements under four funding categories. Those funding categories were described in the RFA as follows:

**New programs** are up to four years long in an eligible country, in a site where the PVO has not previously implemented a BHR/PVC-funded PVO Child Survival Program, awarded through the annual competitive process. PVOs may apply for New programs individually or jointly with other PVOs.

**Follow-on programs** will be funded for periods of up to three years. Follow-on programs are those proposed to further develop an existing program where the PVO has implemented a BHR/PVC-funded PVO Child Survival Program, awarded through the annual competitive process, that follows this program's requirements.

**Mentoring partnership programs** are four-year partnership programs between U.S. PVOs that are current or past recipients of a BHR/PVC-funded PVO Child Survival Program, and other U.S. PVOs with international health and development experience in areas other than community-based child survival that have not received funding under this program.

**Entry Programs** are two-year programs designed for organizations that have never received a cooperative agreement from the BHR/PVC-funded PVO

Child Survival Program and that have limited experience in implementing community child survival programs in developing countries.

Please note that **third-cycle** grants designate those PVOs who have had two previous grants in the same country as their current grant(s). Third-cycle grants are not necessarily consecutive awards.

It is also important to note that descriptions of funding categories have been slightly revised in the FY 2001 RFA. Please consult that RFA for details.

## **B. Application Review Committee**

The USAID Review Committee met from January 19 to February 4, 2000. The committee consisted of four voting members: a representative from the Global Bureau, a representative of the appropriate regional bureau (Africa, Latin America and the Caribbean, Europe and Eurasia, and Asia and Near East), and two reviewers from the Child Survival Division, BHR/PVC. Missions were also invited to score. When score sheets were received from a Mission, they were counted as a fifth voting committee member. The committee reviewed and scored 43 applications based on the criteria found in the RFA for each program category. All program categories were evaluated in the following areas: Proposed Budget, Description of Organization(s), Problem Analysis and Strategy Options, Program Approach, Capacity Building, Sustainability, Child Survival Interventions, Management Plan, and Performance Monitoring and Evaluation.

In addition to mission comments, at least one external specialist reviewed each application for technical strengths and weaknesses; external technical reviewers did not score the applications. These technical reviews were distributed to the review committee prior to the review.

## **C. Analysis of Scoring for this Report**

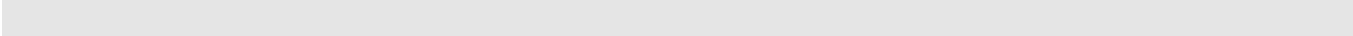
As discussed above, the applications were scored by a committee of four to five voting members. CSTS averaged these voting members' scores for each of the above criteria within each funding category to generate the analyses in this report.

According to USAID/BHR/PVC's rating system, each of the nine evaluation criteria accounted for 5, 10 or 15% of the overall application score and were weighted differently according to funding category. For example, the "Budget" accounted for 10% of the overall score for Entry grant applications while it only accounted for 5% for all other grant application types. Because different denominators were used for rating the different applications according to their funding category, all scores reported in this report have been normalized on a 100-point scale for the purposes of comparison.



# III

## *Key Findings*



This section discusses the range of application scores, breaks the scores out by evaluation criteria, and provides some key observations for potential applicants.

- PVC scored applications for eleven (11) Entry Grants, nine (9) Follow-on Grants, and twenty-three (23) New Grants
- No applications received a score higher than 90
- No Entry Grant applications received a score better than 62, and no Entry Grants were funded this year
- The highest score received for any application was 88.43; the lowest score received for any application was 35.78
- The average overall score for the CSXVI applications was 65.41
- More applications were submitted for New grants (23) than any other category
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- “Budget” and “Problem Analysis and Strategy Options” were the highest scoring evaluation criteria in all funding categories with the exception of third-cycle grants, where “PVO Applicant” and “Problem Analysis and Strategy Options” scored highest.
- “Capacity Building” and “Sustainability” were the lowest scoring evaluation criteria in each funding category, except in third-cycle grants where “Capacity Building” and “Performance Monitoring and Evaluation” scored lowest.

Table 1 illustrates normalized scores by funding category across each of the evaluation criteria. New third-cycle applications scored the highest (79.5), followed by Follow-on applications (70.9), New applications (70.8), Follow-on third-cycle applications (69.5), and Entry applications (48.9).

**Table 1: Normalized DATA**  
Average Scores based on 100 point scale

***	Budget	PVO Applicant	Problem Analysis/ Strategy	Program Approach	Capacity Building	Sustaina -bility	CS Interv	Manag. Plan	Perf M & E	Avg. Score
Entry	58.3	53.5	55.8	53.1	37.0	40.6	44.7	52.2	45.1	48.9
Follow-on	75.5	74.5	76.3	69.6	64.4	66.1	70.1	70.7	71.0	70.9
Follow-on**	69.9	74.1	81.6	75.0	58.3	64.8	66.4	75.7	59.3	69.5
New	73.8	75.5	76.2	69.3	63.8	62.7	67.6	75.4	72.8	70.8
New**	81.3	87.1	83.4	76.8	74.8	74.4	80.4	80.6	77.0	79.5

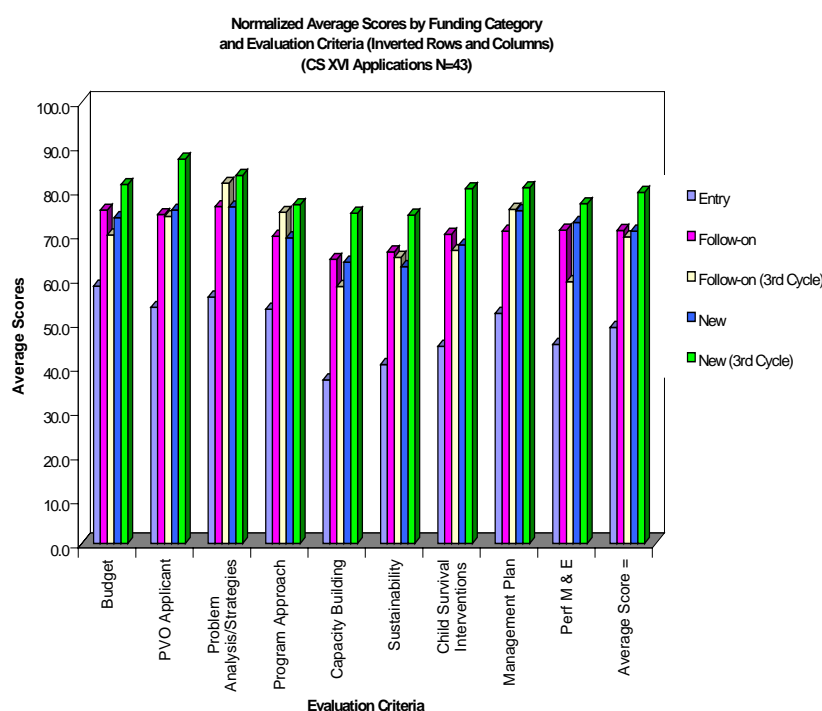
(\*\* 3<sup>rd</sup> Cycle)

\*\*\* Total possible points differ by criteria across funding categories.

Table 1 and Figure 1 illustrate the average scores for the evaluation criteria for each funding category. “Budget” and “Problem Analysis and Strategy Options” scored highest in all funding categories with the exception of third-cycle grants where “PVO Applicant” and “Problem Analysis and Strategy Options” scored highest. “Capacity Building” and “Sustainability” scored lowest in each funding category, except in third-cycle grants where “Capacity Building” and “Performance Monitoring and Evaluation” scored lowest.

Due to the relatively small number of applications received in some funding categories, it is not valid to draw further conclusions by comparing scores across funding categories.

Figure 1



# IV

## *Conclusion*

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The purpose of this document is to present highlights from a quantitative analysis of FY 2000 Application Scores, as well as key themes identified from a qualitative analysis of reviewer comments. Although it is not intended as a “how to” guide for writing successful applications, it is hoped that the information in this report allows this year’s applicants to build on the observations and trends in scores from last year’s applications.

# **ANNEX**

## **A Review of IMCI Programming from CSXVI Grant Applications**

**By John Murray**

## **A Review of IMCI Programming from CSXVI Grant Applications**

**By John Murray**

### **Introduction**

Thirty-nine percent (19) of the applications received by the Child Survival Grants program for 1999 (CSXVI) included a component related to the integrated management of childhood illnesses (IMCI) strategy. It was encouraging to see this many IMCI-related applications, as IMCI is believed to be the most effective approach to preventing and managing early childhood deaths in settings with high infant and child mortality rates. It focuses on the five most important causes of infant and child mortality in developing countries (malaria, malnutrition (including vitamin A and iron deficiency), measles, diarrhea and acute lower respiratory tract infections).

John Murray served as an external reviewer for the IMCI components of each of these 19 applications. Mr. Murray did not score these applications, but submitted extensive reviewer comments to the teams that scored each application. This document synthesizes Mr. Murray's major observations regarding proposed IMCI programming across the portfolio of applicants for CSXVI funding.

John Murray, MB.BS., MPH, is a medical epidemiologist, currently at the University of Iowa. He was formerly a Technical Officer for the BASICS project where he worked on diarrheal disease control, integrated child health program development, evaluation and operations research. During this time he worked on IMCI implementation in Eritrea, Ethiopia, Ghana, and Madagascar, with a special focus on developing integrated monitoring and evaluation methods at health facilities and in communities. Prior to joining the BASICS project, he was a Epidemic Intelligence Service Officer (EIS) at the Centers for Disease Control and Prevention where he also worked on a number of child survival activities in developing countries.

### **Observations**

It was encouraging that several child survival PVO grant proposals included the integrated management of childhood illness (IMCI) strategy. IMCI is believed to be the most effective approach to preventing and managing early childhood deaths in settings with high infant and child mortality rates. It focuses on the five most important causes of infant and child mortality in developing countries (malaria, malnutrition (including vitamin A and iron deficiency), measles, diarrhea and acute respiratory infections).

This review summarizes the major IMCI program gaps identified in the grant proposal reviews.

**Observation 1: *There is a tendency to focus on IMCI case-management training alone without addressing the other elements of the IMCI approach***

There are three components to the IMCI approach;

1. Improving the case management of sick children presented to first-level outpatient facilities by training health workers to use an integrated case management algorithm;
2. Improving the health system supports needed to provide high quality case management to children coming to health facilities or outreach sites (such as a supply of essential drugs, vaccines, equipment and supplies, and regular high-quality supervision);
3. Improving household and community practices to prevent and manage childhood illness in the home and community and to seek preventive and curative care when necessary.

Several proposals focused on IMCI case management training component alone, without addressing the other elements that are important for sustaining health worker practices. These other elements could include the availability of essential drugs, vaccines and supplies, as well as the availability of referral (the ability of severely ill children to be referred to the next level of the health system when necessary). In addition, it is increasingly recognized that changes in the organization of work at health facilities are needed for the successful implementation of IMCI, and this area may also need to be addressed. Although PVOs are often not in a position to influence some of the “system” or “support” factors (such as the national drug distribution system) there are a number of approaches that can be effective locally. Proposals should articulate a plan of activities in this area and budget accordingly.

Although most proposals included a community component, the technical content of household and community activities was not always clear. Regardless of the methods or process used to engage and mobilize communities, it is important that these activities target a limited number of essential household and community health behaviors that are important for reducing infant and child mortality. Definition of a limited number of child health behaviors as a focus for all community behavior change activities can help maximize the potential impact and assure consistency between different project areas. Emphasis behaviors may include behaviors for prevention of illness in the home, better management of sick children in the home when illness occurs, and improved care-seeking for preventive services (such as vitamin A and immunizations) and curative services. Since many preventive, home management and careseeking behaviors will have potential impact on several childhood diseases, this approach is more “integrated.” WHO and UNICEF are currently recommending a limited set of “emphasis behaviors” or “key family practices” as a technical focus for community activities.

For more information see:

- WHO/CHD. August 1997. The management of child illness: rationale for an integrated strategy. WHO, Geneva.
- WHO/CDH. July 1997. Planning for implementation of ICMI in countries. WHO, Geneva.

- BASICS/RPM/WHO. 1998. Drug supply management course. BASICS for USAID, Arlington VA.
- WHO/UNICEF. 1998. The 12 key family practices. WHO, Geneva.
- BASICS. 1997. Emphasis behaviors in maternal and child health: focusing on caretaker behaviors to develop maternal and child health programs in communities. BASICS for USAID. Arlington, VA.
- WHO/CHD. 1997. IMCI in the community: improving family and community practices in support of child health and development. WHO, Geneva.

**Observation 2: *Links with the Ministry of Health are often not clear***

Proposals were not always clear on how IMCI activities were to be coordinated with national and local MOH program staff. It is important that all activities are consistent with national guidelines. MOH staff who have received IMCI facilitator training will often be useful resources for planning and supervising IMCI activities. Where possible, IMCI training for staff in PVO areas should be conducted in collaboration with the national IMCI training program. These links will both ensure that the technical quality of IMCI activities is consistent with national norms and standards, and allow lessons learned from PVO field activities to be transmitted back to the IMCI program and hopefully applied elsewhere in the country. Ideally PVO proposals will make these links clear and establish how lessons learned will be used to inform the national and local IMCI program. Activities that are developed and conducted in collaboration with MOH staff are more likely to be sustainable in the longer term.

**Observation 3: *Materials that will be used for IMCI training are not always clear***

It is important that the core technical content of the IMCI training materials is retained and that the materials have been adapted for local use.

*1. Technical content of the IMCI training materials*

It is important that the core technical content of the generic WHO IMCI materials be retained since the case management guidelines in these materials are based on data—the relative sensitivity and specificity of the case management steps have been tested in a variety of clinical settings. Other guidelines on counseling and home case-management are also based on data from field studies. It is not appropriate to modify the case-management algorithm, or to remove certain components of it. Combined vertical training programs (ARI and CDD training, for example) do not represent an “integrated” approach to the management of sick children.

The generic materials *do* need to be adapted for local country use, but this process (see below) does not change their core technical content.

For more information see:

- Gove S. for the WHO working group on guidelines for IMCI. 1997. Integrated management of childhood illness by outpatient health workers: technical basis and overview. *Bull WHO*; 75 (Supplement 1): 7-24.

## 2. *Adaptation*

It is important that the IMCI training materials are adapted for local use. The adaptation process includes: modifying the assessment, classification and treatment guidelines for the local epidemiologic profile of the country and to be consistent with local treatment policies and practices; developing nutritional counseling guidelines (the nutrition food box) based on local foods and feeding practices—this often requires the collection of qualitative data; and the insertion of local words and terms so that the counseling guidelines can be understood locally. The adaptation process requires some time (in many countries from six months to a year, and is often done by the IMCI coordinating group). Training materials that have not been adapted to the local conditions should not be used.

When IMCI has already been implemented in a country, the ministry of health will already have adapted materials—these should be used by PVOs for training.

If adapted IMCI training materials are not available, PVOs should make a decision as to whether or not they want to proceed with IMCI training before there is national adoption of the strategy and adaptation of materials. If there is agreement with MOH staff for the IMCI approach to be used in the PVO areas, then PVO staff will need to collaborate with MOH staff (locally and nationally) to adapt the generic materials to the local context. In this case, the project plan will need to include time and resources to complete the adaptation process.

For more information see:

- WHO/CHD. 1997. Adaptation of technical and training materials for the course on IMCI. WHO, Geneva
- WHO/CHD. 1997. IMCI Adaptation guidelines: Manual. WHO, Geneva. (Some copies of the manual may be available from BASICS).

## **Observation 4: *Training methods to be used are often not described***

Three approaches to training have been used in countries implementing IMCI. PVOs should decide which of these methods are to be used and then plan and budget accordingly. The quality of training will be higher and more sustainable in the long term if local trained staff are used. These staff will usually be MOH staff who have received IMCI facilitator training.

### *1. Standard training using adapted generic IMCI materials: for first level health workers.*

This is the most frequently conducted training. The course is 11 days in duration and involves considerable clinical practice in both the hospital setting and in outpatient



clinics. Trained IMCI facilitators are needed. The course is usually coordinated by a senior staff person with experience running the course in other countries. Hospital and outpatient facilities that see enough sick children to provide a sufficient number of cases are used; clinical staff are needed to coordinate the clinical practice sessions. The training involves a number of strategies including reading, role plays, videos and question/answer sessions as well as clinical practice.

Ideally, PVOs will coordinate with the national IMCI training program in order to train staff in project areas. If it is not possible to link with the on-going national IMCI training program, PVOs may want to organize local IMCI training. It is important that this be done in close collaboration with the national and regional IMCI program staff and that trained facilitators are used. Proposals should plan and budget for setting up and conducting this type of training. PVO staff planning and supervising project activities should also plan to undertake IMCI training—either with national training programs or through periodic regional IMCI training coordinated by WHO. BASICS also periodically collaborates with national programs to conduct IMCI training and may provide training opportunities for PVO staff.

For more information see:

- WHO/CHD. 1997. IMCI training course for first level health workers: linking integrated care and prevention. WHO, Geneva.
- WHO/CHD. 1995. IMCI training modules and facilitator guidelines. WHO, Geneva. (some sets of these materials are available from BASICS).

## *2. IMCI complementary course training: for first level health workers with limited literacy*

This course was developed by BASICS and World Education in collaboration with WHO. It is designed for first level health workers with limited literacy skills—these health workers have difficulty completing the standard IMCI course which requires that they read approximately 500 pages of material and complete written exercises. The core technical content of the complimentary course is identical to the standard IMCI course. The course uses a variety of adult learning techniques (using participatory methods) which involve less reading. The course was field tested in Zambia in November 1997 and subsequently adapted for use in Bolivia where it was tested at the end of 1998. The current version of the course is three weeks in duration—this may be prohibitive in some situations. IMCI-trained facilitators are trained to conduct the complimentary course using a *Facilitator Training Program Module*.

For more information see:

- BASICS. 1998. IMCI Complementary Course Materials. BASICS for USAID, Arlington VA.
- BASICS. November 1997. IMCI complementary course field test. Technical report. BASICS for USAID, Arlington VA.
- Beth Gragg, Senior Program Officer, World Education; bgragg@worlded.org

- David McCarthy, Technical Officer, BASICS: dmccarthy@basics.org

### *3. IMCI training for community health workers*

In countries with limited access to health facilities community health workers may be the only source of primary health care. In these settings community health workers can be trained to use the IMCI approach to manage and refer sick children. This approach is only possible in settings where MOH policies are supportive of this approach, and where community health workers are permitted to give simple drugs in the community. CHW training using the core IMCI technical content has been developed and used by CARE in Kenya. Follow-up after the Kenya CHW training indicated that the performance of CHWs was consistent with IMCI standards. Other PVOs may also have developed technically sound IMCI training materials for community health workers.

### ***Observation 5: Methods for sustaining health worker performance after IMCI training are often not described***

Proposals were often not clear on how the performance of health workers will be sustained after IMCI training. Training alone is unlikely to result in sustained changes in health worker performance. WHO currently advocates a single follow-up visit to health workers approximately one month after IMCI training. At this visit, health workers are observed managing sick children using the IMCI patient checklist, and feedback given directly on case management practices. In addition, several other facility supports, such as essential drugs and equipment are checked. This method encourages the use of these data to solve problems immediately. In several countries, this approach has been adapted as a supervisory method that can be applied regularly over time by supervisors. Critical to a supervisory approach is that health worker practice is observed in a standardized way, that problems are discussed, and health workers are encouraged to solve problems themselves with locally available resources. Supervisory methods should use existing staff and systems. PVO proposals should plan and budget for the development of supervisory tools, and strategies for applying these over the longer term. If regular clinical supervision is not feasible, then there are other methods, such as self assessment tools, that have been tested in some settings.

For more information see:

- WHO/CHD. July 1997. Follow-up after IMCI training: reinforcing the case management skills of first level health workers. WHO, Geneva.
- WHO/CHD. 1998. Guidelines for follow-up after IMCI training: manual. WHO, Geneva.
- Burnham, G. 1997. Development of IMCI supervision for BASICS Zambia. Report of consultancy. BASICS trip report. BASICS for USAID. Arlington, VA.
- Simoes, EAF et al. 1997. Performance of health workers after training in integrated management of childhood illness in Gondar, Ethiopia. *Bull WHO*;75(supplement 1):43-53.

- Loevinsohn, BP, Guerrero, ET, Guerrero, SP. 1995. Improving primary health care through systematic supervision: a controlled field trial. *Health Policy and Planning*;10(2):144-153.

**Observation 6: *Indicators and methods for monitoring and evaluating IMCI at health facilities are often not described***

Proposals often did not include indicators for monitoring and evaluating the quality of care at health facilities over time following IMCI training. A limited set of core indicators for measuring the quality of care at health facilities has been developed by the interagency working group on IMCI monitoring and evaluation, coordinated by WHO. It is hoped that this core list of indicators will be used widely—these indicators were selected to be valid, reliable and measurable. PVOs should review this list of core indicators and consider using them to evaluate quality of care over time at health facilities.

IMCI indicators measure information on how children are assessed, classified, treated and counseled. Direct observations of practice required to measure these indicators, as well as exit interviews with caretakers of young children when they leave facilities. In addition, a number of “systems” indicators which look at the availability of essential drugs, supplies, equipment, vaccines and supervision are included.

A number of methods can be used to collect this type of facility information. Regular data for monitoring can be collected from routine visits using checklists, or from routine reports. Data for evaluation purposes are usually collected using a health facility survey approach.

For more information see:

- *WHO/CAHD and the interagency working group on IMCI monitoring and evaluation. September 1999. Indicators for IMCI at first level health facilities and households. WHO, Geneva*
- *WHO/CAHD and the interagency working group on IMCI monitoring and evaluation. 1999. Monitoring and evaluation of facility services for IMCI. WHO, Geneva.*
- *M and E summary document*
- *WHO/CAHD and the interagency working group on IMCI monitoring and evaluation. 1999. Draft integrated health facility survey. WHO, Geneva.*
- *Murray, J. and Manoncourt S. 1998. Integrated health facility assessment manual. using local planning to improve the quality of child care at health facilities. BASICS for USAID, Arlington VA*
- *WHO/Geneva. 1994. Health facility survey manual: Diarrhea case management. CDD/SER/90.1 (Rev.1 1994), and the same for ARI case management.*

**Observation 7: *Strategies for improving capacity for district planning and management of IMCI activities are often not included***

It is important that district staff have the capacity in the long term to plan and budget IMCI activities at health facility and community levels. In order to do this, they need to understand how to monitor and evaluate IMCI program activities, and to have experience implementing at the facility and community levels. It is particularly important that they understand the elements important for sustaining performance over time using methods such as clinical supervision and feedback, regular monitoring of performance, and participatory community methods. PVOs are well placed to involve district staff in program implementation, and to work with them to develop IMCI work plans and budgets. By clearly linking with district staff, they will help build local capacity for management and planning in the long term and help ensure that lessons learned in the project areas are applied elsewhere. Proposals should plan and budget activities which help to build this capacity.

For more information see:

- Omaswa F, Burnham G, Baingana G, Mwebesa H, Morrow R. 1997. Introducing quality management into primary health care services in Uganda. *Bull WHO*;75(2):155-161.
- Agyepong IA. 1999. Reforming health service delivery at district level in Ghana: the perspective of a district medical officer. *Health Policy and Planning*; 14(1):59-69.